STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	06/20/2011

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NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN46202

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F0000	This visit was for Recertification and State Licensure Survey. Survey Dates: June 13, 14, 15, 16, 17 & 20, 2011 Facility Number: 000131 Provider Number: 155226 Aim Number: 100274910 Survey Team: Diana Zgonc RN TC Connie Landman RN Courtney Hamilton RN Christi Davidson RN Census Bed Type: SNF/NF: 90 SNF: 24 Total: 114 Census Payor Type: Medicare: 24 Medicaid: 81 Other: 9 Total: 114 Sample: 31 Stage 2	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a Desk review on or after 07/05/11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/22/11 Cathy Emswiller RN			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure the environment in the locked memory care unit was free from accident hazards with the potential to effect 22 residents. Findings include; During an observation on 06/14/11 at 10:25 a.m. until 10:35 a.m., a set of keys was observed hanging from the key hole on the unit elevator across from room 304. The elevator doors were shut. These elevator doors	F0323	**F 323** It is the practice of this provider to ensure that residents environment be free of accident hazards and that each resident receives adequate supervision and assistive devices to prevent accidents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Keys were removed at time of discovery, and staff stayed next to elevator to ensure that it had not been sent up to the unit. Memory care facilitator did an immediate head count of residents on unit to ensure that none had left the unit.	07/05/2011

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	accessed the memory care unit on the third floor of the facility. During an observation on 06/14/11 from 10:25 a.m. until 10:29 a.m., the keys went unnoticed by LPN #7 and Activities Staff Member #8 that walked by these elevator doors. During an observation on 06/14/11 at 10:31 a.m., the DoN entered the unit and walked past the keys. During an observation on 06/14/11 at 10:35 a.m., the DoN saw the keys on her way to exit the unit. The DoN questioned the staff to identify who the keys belonged to. No staff on the unit claimed the keys. The DoN called the housekeeping staff #12. During an observation on 06/14/11 at 10:39 a.m., the housekeeping staff #12 and housekeeper #11 entered the unit through the elevator doors where the keys were left. During an interview with the DoN on 06/14/11 at 10:40 a.m., the DoN indicated the housekeeping staff #12		How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who reside on the Augustes Cottage memory care unit have the potential to be affected by this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: All staff that have access to or utilize the elevator access keys to the memory care unit will be inserviced by the Staff Development Coordinator on use and removal of keys for elevator access. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Customer Care rounds audit sheet will be used by the Department Directors , or designee, as the monitoring CQI tool. CQI tool will be completed weekly x4, monthly x2, then quarterly thereafter until the threshold is met.	

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	would address the situation with housekeeper #11. A One-on-One In-Service Record dated 05/02/11 indicated housekeeper #11 had been educated on operating the elevator on the memory care unit. During an interview with the DoN on 06/20/11 at 9:25 a.m., the DoN indicated there were 22 residents on the memory care unit on 06/14/11. During an interview with Maintenance Supervisor #9 on 06/20/11 at 11:00 a.m., the Maintenance Supervisor #9 indicated he expected the keys to be removed from the elevator when a staff member used the elevators on the locked unit. 3.1-45(a)(1)			

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F0334 SS=C	The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes			

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	documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. Based on record review and interview, the facility failed to ensure 3 of 5 residents or resident's legal representatives reviewed for Influenza and pneumococcal immunizations received education, information or an opportunity to refuse the immunization each time the immunization was administered out of a total stage two sample of 31. (#99, #112, #113) Findings included: 1. The record for Resident #99 was reviewed on 06/16/11 at 10:03 a.m.	F0334	**F 334** It is the practice of this provider to offer the influenza immunization annually from October 1 through March 31, it is also the policy that the resident or the residents legal representative be provided with education on the benefits and potential side effects , and have the opportunity to accept or decline the vaccine annually. It is also the practice of this facility to offer each resident the pneumococcal vaccine, to provide the resident or the residents legal representative with education regarding the benefits and potential side effects of the pneumococcal vaccine, and the opportunity to accept or decline the vaccine. **What corrective action(s) will be**	07/05/2011

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	Diagnoses included, but were not limited to, Alzheimer's dementia, ataxia, hypertension, vitamin D deficiency and a history of alcohol abuse A recapitulation, dated for the month of June 2011, indicated Resident #99 may have yearly mantoux (tuberculosis) and flu (influenza) vaccine. A recapitulation for Resident #99, dated for the month of June 2011, with a current physician's order indicated, "...May have Pneumovax 5/2/11...." A vaccination record for Resident #99, indicated, "...11/1/10 Flu Vac {Influenza vaccine}...5/16/11 Pneumovac {Pneumococcal vaccine}...." The record for Resident #99 lacked documentation of a pneumococcal or influenza immunization consent form for 2010 or 2011.		**accomplished for those residents found to have been affected by the alleged deficient practice**? For all residents who had not received influenza vaccine or pneumococcal vaccine their responsible parties and physicians were notified, and consent or declination was received after education was provided to families. All residents for whom consents were received the vaccines were administered. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken.** Each residents medical record will be audited for consent or declination in the previous calendar year to determine residents who have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur.** Each resident will have pneumococcal re-offered, along with education provided to responsible parties. A consent/declination for current calendar year will be obtained. All residents with new consent will have physician contacted, and immunization administered. Beginning September 1, 2011 facility staff will begin	

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	2. The record for Resident #112 was reviewed on 06/16/11 at 2:27 p.m. Diagnoses included, but were not limited to, aphasia, dysphagia, hypertension, cerebral vascular accident and lung nodule. A recapitulation, dated for the month of June 2011, indicated Resident #112 may have yearly flu and mantoux vaccine. A vaccine record for Resident #112, indicated, "...11/31/10 Flu Vac...5/31/11 Pneumovax...." The record for Resident #112 lacked documentation of a pneumococcal or influenza immunization consent form for 2010 or 2011. 3. The record for Resident #113 was reviewed on 06/17/11 at 8:28 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia, gastrointestinal reflux disease, and seizure disorder.		contacting responsible parties in anticipation of the upcoming influenza season, provide education, and obtain new consent or declination. All residents with a current consent will receive vaccinations between October 1, 2011 through March 31, 2012. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place.** CQI tool will be utilized weekly until compliance is reached, and then monthly. ****Beginning in September the CQI tool will be completed weekly until compliance is reached, and then monthly through March 31, 2012 by the DNS or designee.	

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A recapitulation, dated for the month of June, indicated Resident #113 may have yearly flu, pneumonia and mantoux vaccine.

A vaccine record for Resident #113, indicated, "...10/11/10 Flu Vac per Hosp {hospital}...10/11/10 Pneumovac per Hos...."

The record for Resident #113 lacked documentation of a pneumococcal or influenza immunization consent form for 2010 or 2011.

During an interview with the DoN on 06/16/11 at 2:40 p.m., the DoN indicated, there have been changes in the medical records department. The DoN indicated there was a binder that maintained all yearly pneumococcal and influenza consents for each resident. The DoN indicated she would provide the binder in the a.m.

During an interview with the DoN on 06/17/11 at 11:10 a.m., the DoN provided the binder with consents. The DoN indicated she did not get

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	155226	A. BUILDING 00 B. WING	06/20/2011

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	new consents each year because of the wording of the facility consent. The binder contained an influenza consent for Resident # 99 dated 10/28/08 and a pneumococcal immunization consent for Resident #99 dated 09/04/08. The binder contained an influenza consent for Resident #112 dated 06/25/09 and a pneumococcal immunization consent for Resident #112 dated 06/25/09. The binder contained an influenza consent for Resident #113 dated 08/03/09 and a pneumococcal immunization consent for Resident #113 dated 08/03/09. No further consents were provided for Residents #99, #112 or #113. 3.1-13(a)			

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F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure dietary staff washed their hands for the required 20 seconds between tasks during meal service for 4 of 6 dietary employees observed for hand washing (FSS {Food Service Supervisor] #3, DA [Dietary Aide] #4, Cook #5, and DA #6). This practice had the potential to affect 108 of 114 residents in the facility. Findings include: During the lunch meal service, observed on 6/13/11 at 12:00 P.M., Cook #5 took an empty pan from the steam table and placed it in the 3 compartment sink, went to the hand washing sink and washed her hands for 12 seconds. Cook #5 then went back to the steam table and once	F0371	**F 371** It is the practice of this provider to procure food from sources approved or considered satisfactory by federal, state or local authorities, and to store, prepare, and distribute and serve food under sanitary conditions. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** All dietary staff was reinstructed on hand washing practices by Registered Dietitian on 6/30/11. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken**. All residents who receive food or fluids from facility kitchen have the possibility to be affected by this alleged deficient practice. **What measures will be put into**	07/05/2011

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	again started serving food. FSS #3 was observed leaving the kitchen, returning a minute later and took food from the oven to the steam table. FSS #3 then washed her hands for 10 seconds and began going in and out of the walk-in refrigerator, heating soup in the microwave, dipping applesauce, taking sandwiches from the oven to the steam table, cooking grilled cheese sandwiches, and taking french fries from the oven to the steam table. DA #4 was observed placing plastic wrap from dessert dishes into the trash can, which she had touched to open the lid, washing her hands for 10 seconds before returning to placing desserts and silverware on trays.. DA #6 was observed throwing a paper towel she had picked up off the floor into the trash, then washed her hands for 12 seconds before returning to the tray line. A current facility policy, dated 5/06, provided by the Administrator on 6/14/11 at 8:20 A.M., titled "Food Handling Policy" indicated: "... Procedure:		**place or what systemic changes you will make to ensure that the alleged deficient practice does not recur.** All dietary personal will be re-inserviced on hand washing standards and food handling practices. All dietary staff will have a hand washing skills validation completed by Registered Dietician. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place.** **** CQI hand washing monitoring tool will be completed by the Registered Dietician weekly x4, monthly x2, and quarterly thereafter until threshold has been met.	

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	1. Food employees (any individual working with food, food equipment or utensils, or food-contact surfaces) will clean their hands and exposed portions of their arms before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: ...c) After handling soiled surfaces, equipment or utensils;. ... e) Directly before touching ready-to-eat food or food-contact surfaces;..." The current facility policy lacked documentation of an amount of time to wash hands. During an interview with the DON (Director of Nursing) on 6/17/11 at 8:30 A.M., she indicated 108 residents in the facility received meals from the kitchen, the other 6 residents were not receiving oral food or fluids. During an interview with the Dietician on 6/15/11 at 8:00 A.M., she indicated the expectation was the kitchen staff			

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	would wash their hands for at least 20 seconds. 3.1-21(i)(3)			
F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation and interview, the facility failed to ensure insulin was not expired in 1 of 6 med carts	F0425	**F 425** It is the practice of this provider to provide routine, and emergency drugs and biologicals to the	07/05/2011

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	155226	A. BUILDING 00 B. WING	06/20/2011

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	checked for expired medications. Findings include: Observation of the medication cart on the 3rd floor vent unit on 06/17/2011 at 9 A.M. indicated an open vial of Lantus (insulin). There was no open date on the vial. The fill date on the insulin was 05/09/2011. An undated policy titled, "48.03 Guide for Storage of Insulin" provided by the Director of Nursing (DON) on 06/17/2011 at 10:50 A.M., indicated expiration of an opened vial of Lantus to be "...28 days". An interview with LPN #2 on 06/17/2011 at 9 A.M. indicated she would dispose of the insulin. 3.1-25(o)		residents. It is also the practice of this facility to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The insulin that was potentially expired was removed from the medication cart, and replaced with a previously unopened vial. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who receive insulin have the potential to be affected by this alleged deficient practice. Each medication cart was checked immediately during the survey process by the unit managers to ensure that they did not contain any expired insulin. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: All licensed nurses or QMA's were reinserviced on 6/30/11 by the Staff Development Coordinator on the labeling, storage, and expiration dates of insulin.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0431 SS=D	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.		How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Medication storage review CQI tool will be utilized weekly x4, monthly x2, and then quarterly thereafter, to be completed by DNS or designee.	

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	Based on observation and interview, the facility failed to ensure opened vials of insulins contained open dates in 1 of 6 med carts checked for expired and dated medications. Findings include: Observation of the medication cart on the 3rd floor vent unit on 06/17/2011 at 9 A.M. indicated 3 open vials of Lantus, Humalog and Novolin (insulins). The vials did not contain open dates. An undated policy titled "48.03 Guide for Storage of Insulin" provided by the facility on 06/17/2011 at 10:50 A.M., lacked documentation of procedures for dating open insulin vials. The policy indicated the expiration dates for the open vials of Lantus, Humalog were "...28 days" and "...30 days" for the Novolin. An interview with LPN #2 on 06/17/2011 at 9 A.M. indicated she would dispose of the insulin. 3.1-25(o)	F0431	**F 431** It is the practice of this provider to have drugs and biologicals labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All medication carts were inspected and insulin which did not have open dates were immediately removed from the medication cart and replaced. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who receive insulin have the potential to be affected by this alleged deficient practice. Each medication cart was checked to ensure that they did not contain any insulin without labeled open dates. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: All licensed nurses or QMA's were reinserviced by the Staff Development Coordinator on 6/30/11 on the labeling, storage, and expiration dates of insulin. Any insulin found without an open date or expiration	07/05/2011

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			date will be destroyed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Medication storage review CQI tool will be utilized weekly x4, monthly x2, and then quarterly therafter, to be completed by DNS or designee until threshold is met.	
F9999	Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. This requirement was not met as evidenced by: This requirement was not met as evidenced by: Based on interview and record review the facility failed to ensure a Licensed Practical Nurse (LPN) had a valid nursing license for 1 of 32 LPN's and Registered Nurses (RN) reviewed for licenses. (LPN#1) Findings include: Review of licensure status from state	F9999	**F 9999** It is the practice of this provider to utilize professional staff who are licensed, certified, or registered in accordance with applicable state laws or rules. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The identified nurse was removed from the schedule until licensure was updated to show as 'active'. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents receiving care under identified staff person have the ability to be affected. All other professional staff licenses were rechecked using the PLA website with all other staff members having an active license.	07/05/2011

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	of Indiana provided by the Administrator on 06/20/2011 at 9:35 A.M., indicated LPN #1's license expired 10/31/2010. LPN #1 was observed working as the second floor Unit Manager 06/13/2011 through 06/17/2011. An interview with the DON on 06/20/2011 at 8:35 A.M., indicated LPN #1's license was expired and she had been taken off the schedule. 3.1-14(s)		What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Staff development coordinator was inserviced by DNS on 6/30/11 on validating professional licenses upon hire, and when nearing expiration. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: *** audit tool to be used to ensure licenses have been validated as active prior to start of floor orientation, and then completed for each profession as expiration dates near by Staff development coordinator or designee.	